			DER/SUPPLIER/CLIA FICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5884AGC		A. BUILDING B. WING		C 12/13/2010	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1	
NAZAREN	E SENIOR CARE HOME		5362 TOPA LAS VEGA	AZ ST S, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
Y 000	Initial Comments The findings and conclusions of any investigation		ation	Y 000			
	by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.						
	This Statement of Deficiencies was generated as a result of an complaint investigation conducted on your facility from 11/15/10 through 12/2/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.						
	for Group beds for eld Category II residents. the survey was three.	d for four Residential Faderly and disabled pers The census at the time One resident file was ployee files were review	ons, e of				
	Other deficiencies we investigation. See Ta 0069, Tag 0070, Tag	te level of care was ag 0740 and Tag 0743 are identified during the g 0067, Tag 0068, Tag 0100, Tag 0105, Tag 0107, T	J				
	facility was not substa	901 - The allegation e sore precautions take antiated through observ terview of the resident a	ation				
Y 067 SS=A		cations of Caregiver- Re	ead	Y 067			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5884AGC		A. BUILDING B. WING			C 3/2010
NAME OF PR	ROVIDER OR SUPPLIER	NV33004AGC	STREET ADD	I RESS, CITY, STA	ATE. ZIP CODE	12/1	3/2010
	IE SENIOR CARE HOME		5362 TOPA				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 067 Y 068 SS=D	and 3 of this regulation sign a statement that provisions. This Regulation is not Based on record reviet failed to ensure that 1 provisions of NAC 44 signed a statement thregulations (Employe Severity: 1 Scope: 449.196(1)(d) Qualified	sidential rovisions of NAC inclusive, and sections on and he has read those of met as evidenced by: ew on 11/23/10, the fact of 5 caregivers read th 9.156 to 449.2766 and nat he has read those e #2). 1 cations of anguage	ility	Y 067			
	(d) Demonstrate the a write, speak and under English language. This Regulation is no						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM		BER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		NVS5884AGC		A. BUILDING B. WING		12	C / 13/2010
NAME OF PR	ROVIDER OR SUPPLIER	1	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NAZARENE SENIOR CARE HOME 5362 T LAS V				AZ ST S, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 068	Continued From page 2			Y 068			
	1 of 5 caregivers that could not read, write, speak and understand English (Employee #2).		speak				
	Severity: 2 Scope: 1	1					
Y 069 SS=J	449.196(1)(e) Qualifications of Caregiver-Meet needs			Y 069			
	NAC 449.196 1. A caregiver of a refacility must: (e) Possess the apprknowledge, skills and the needs of the residuality.	ropriate d abilities to meet					
	Based on observatio interview from 11/23/ facility failed to ensur	/10 through 12/2/10, the re 1 of 5 caregivers opriate knowledge, skills	:				
	Findings Include:						
	11/6/10. He was a 7 admitted to the facilit hospital for a C2 fractincluding cervical spi subdural hematoma, fractures, pulmonary and maxillary sinus fi fracture was placed to A letter written by the	nitted to the facility on 1 year old male who way after treatment at a locture, multiple fractures ne fracture, skull fractur right eight and ninth rib contusion, pneumocepracture. A halo and bra by the physician on 10/16 facility instructed the	re, halus ce for 13/10.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		ER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NVS5884AGC		A. BUILDING B. WING	/ING		3/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		0.2010
NAZAREN	E SENIOR CARE HOME		5362 TOPA LAS VEGAS	Z ST S, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Y 069	Continued From page	e 3		Y 069			
1 009	caregivers not to use assist in mobilizing the the caregivers not to any reason. According to interview Employee #3, on the Employee #2 pulled Feethe halo brace and vershouted for Employee halo. Employee #2 cout of bed by the brace Resident #1 complaint transported to the host the halo pins and screw #1 was discharged from transferred to the faction of the halo pins and screw #1 was discharged from transferred to the faction According to interview 11/23/10 and 11/24/11 have evidence of care An interview with Empreyealed he moved to Philippines five month working for the facility #2 acknowledged he States long and can complete the care acknowledged the was cardiopulmonary first aid training. The	the halo brace or vest to patient. It also instruadjust the vest or screw with Resident #1 and afternoon of 11/16/10, Resident #1 out of his best of the halo. Resident #2 to stop touching the ontinued to lift Residence and vest of the halo. The halo had of pain and was spital two hours later to lews re-secured. Resident the hospital and willity on 11/17/10.	ed by ht #1 e t #1 have ent eted sh. red nd hly	1 009			
	Severity: 4 Scope	:: 1					
Y 100 SS=D	449.200(1)(a) Person	nel File - Employee Inf	0	Y 100			
	NAC 449.200						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		NVS5884AGC		B. WING		12/1) 3/2010
NAME OF PR	ROVIDER OR SUPPLIER	14403004AGG	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	12/1	3/2010
NAZAREN	IE SENIOR CARE HOME		5362 TOPA LAS VEGA	Z ST S, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 100	Continued From page 4			Y 100			
	a separate personnel member of the staff of	e provided in subsection file must be kept for ear far facility and must incomes, telephone number a far of the employee.	ach lude:				
	Based on record revie failed to ensure the na	of met as evidenced by: ew on 11/23/10, the fact ame, address, telephor curity number was provioloyee #2).	ility ne				
	Severity: 2 Scope: 1						
Y 101 SS=A	449.200(1)(b) Person	nel File - date of hire		Y 101			
	a separate personnel member of the staff of	e provided in subsection file must be kept for east a facility and must incont the employee began had be sidential facility.	ach lude:				
	Based on record revie	ot met as evidenced by: ew on 11/23/10, there v employees (Employee	vas				
Y 102 SS=A	449.200(1)(c) Personi	nel File - Training Recc	ords	Y 102			

AND DUAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NY050044.00		A. BUILDING B. WING		C	
NAME OF DE	ROVIDER OR SUPPLIER	NVS5884AGC	STREET AND	 RESS, CITY, STA	ATE ZIP CODE	12/13/201	10
NAME OF PR	ROVIDER OR SUPPLIER		5362 TOPA		KIE, ZII GODE		
I NAZADENE SENIOD CADE HOME I				S, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETE DATE
Y 102	Continued From page	e 5		Y 102			
	a separate personnel member of the staff o	ee provided in subsection file must be kept for ea of a facility and must inc to the training received I	ach lude:				
Y 103 SS=D	Based on record reviet failed to ensure 1 out #2) had evidence of to Severity: 1 Scope: 1	-	ility	Y 103			
	NAC 449.200 1. Except as otherwis a separate personnel member of the staff o	se provided in subsection file must be kept for east a facility and must incure ates required pursuant for the employee.	ach lude:				
	Based on record review failed to ensure 1 of 5	•	ility				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		ER:			(X3) DATE SURVEY COMPLETED		
		NVS5884AGC		A. BUILDING B. WING		12/1:	3/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		0/2010
NAZAREN	E SENIOR CARE HOME		5362 TOPA LAS VEGAS	Z ST S, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 104	Continued From page	e 6		Y 104			
Y 104 SS=D	449.200(1)(e) Personnel File - References			Y 104			
	a separate personnel member of the staff o (e) Evidence that the	e provided in subsection file must be kept for ear f a facility and must incommererences supplied by the residential faced by the residential face	ich lude: the				
	Based on record revie failed to investigate the employees (Employee						
	Severity: 2 Scope: 1	1					
Y 105 SS=D	449.200(1)(f) Personn	nel File - Background C	heck	Y 105			
	a separate personnel member of the staff of	e provided in subsectio file must be kept for ea f a facility and must inc iance with NRS 449.17	ıch lude:				
	Based on record review failed to ensure 1 of 5	quirements of NRS 449	ility				
	Severity: 2 Scope: 1	1					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5884AGC		B. WING		C 12/13/2010	
NAME OF DE	ROVIDER OR SUPPLIER	NV33004AGC	STREET ADDE	I RESS, CITY, STA	ATE ZIP CODE	12/13/2010	
NAME OF PR	ROVIDER OR SUPPLIER		5362 TOPA		KIE, ZII GODE		
NAZAREN	IE SENIOR CARE HOME		LAS VEGAS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
Y 107 SS=A	449.200(2)(b) Person	nel File - 18 yrs of age		Y 107			
	information required p	for a caregiver of a st include, in addition to oursuant to subsection egiver is 18 years of ag	1,				
	Based on record revie		ility				
Y 108 SS=C	449.200(3) Per File -	Storage & Availability		Y 108			
	NAC 449. 200 3. The administrator repersonnel files for the locked cabinet and motherwise provided in restrict access to this other employees of the Copies of the docume evidence that an emporary result to perform fire cardiopulmonary result the employee has been tuberculosis must be review at all times. The shall make the person	ay, except as this subsection, cabinet by the facility. ents which are loyee has been st aid and the facility and that the tested for available for the administrator					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5884AGC		A. BUILDING B. WING		12/1:	; 3/2010
NAME OF PR	ROVIDER OR SUPPLIER	NVSSUOFAGE	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	12/1	5/2010
NAZAREN	IE SENIOR CARE HOME		5362 TOPAZ ST LAS VEGAS, NV 89120				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE PROPRIES	JLD BE	(X5) COMPLETE DATE
Y 108	available for inspection by the bureau			Y 108			
	within 72 hours after requests to review the	the bureau					
	Based on record revious 11/23/10, the facility the tuberculosis records a	failed to ensure caregiv and proof of first aid and uscitation training were	er				
	Severity: 1 Scope: 3	}					
Y 740 SS=D	449.272(1)(a)-(c) Ind	welling Catheter		Y 740			
	catheter must not be facility or be permitted a residential facility upon (a) The resident is phonographic or with or without the as (b) Irrigation of the can accordance with the permedical professional provide that care. (c) The catheter is instaccordance with the can accordance with the can accordance with the can accordance with the catheter is instaccordance with the catheter is instaccordance.	ysically and mentally all aspects of the condisistance of a caregiver of the condisistance of a caregiver of the condisistance of a caregiver of the caregiver of a caregiver of a who has been trained to caregiver of a physician by who has been trained to the caregiver of a physician by who has been trained to the caregiver of a physician by who has been trained to all aspects of the caregiver o	al nt of tion, o ly in				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G	X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMB	LIV.	A. BUILDING		С		
		NVS5884AGC		B. WING		12/13/2010		
	OVIDER OR SUPPLIER	:	5362 TOPA	ADDRESS, CITY, STATE, ZIP CODE OPAZ ST EGAS, NV 89120				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE		
Y 740	This Regulation is no Based on interview a 11/23/10, the facility a resident who was not	ot met as evidenced by: nd record review on admitted and retained a mentally and physicall; all aspects of an indwe	ı y	Y 740				
	Severity: 2 Scope:	1						
Y 743 SS=F	facility with a resident indwelling catheter shad (a) The bag and tubin changed by: (1) The resident, wassistance of a caregoration (2) A medical profest trained to provide that (b) Waste from the used disposed of properly. (c) Privacy is afforded being provided; and (d) The bag of the caregoration.	ployed by a residential twho requires the use of all ensure that: ag of the catheter are with or without the giver. essional who has been to care. See of the catheter is do not to the resident while of the terms o	are is	Y 743				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING			С
		NVS5884AGC		b. WING		12	2/13/2010
	ROVIDER OR SUPPLIER	E	STREET ADDR 5362 TOPAZ LAS VEGAS		.TE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Y 743 Y 853 SS=D	Based on record rev 11/23/10, the facility employees received symptoms of urinary dehydration (Employ Severity: 2 Scope 449.274(3)(a) Medic NAC 449.274 3. A written record or injuries and illnesses which occur in the farmade by the caregived discovers the accide illness. the record m (a) The date and time or injury or the date the illness was discontained to injury or the date the illness was discontained to injury or the date the illness was discontained to injury or the date the illness was discontained to injury or the date in injury or the date in injury or the date in injury or the date illness was discontained in injury or the date in injury or the date illness was discontained in its interest of the injury or the facility. This Regulation is in Based on record reverse or injury or the facility report was written up in its interest of the injury or the facility report was written up in its interest of the injury or	not met as evidenced by: iew and interview on failed to ensure 5 out of training in signs and rece #1, #2, #3 and #4). E: 3 al Care / Records f all accidents, s of the resident acility must be er who first ent, injury or ust include: e of the accident and time that evered. company the eferred to not met as evidenced by: iew and interview on failed to ensure an incident foon the injury and resident (Resident #1).	f 5	Y 743			